

RHEUMATOLOGY ENROLLMENT FORM - "SPECIALTY"

PATIENT INFORMATION

TREATMENT ARRANGEMENTS

Last Name _____ First Name _____
 Social Security # _____ Date of Birth _____
 Address: _____
 Sex M F Wgt: _____ Ht: _____ Phone: _____
 Allergies: _____ Cell: _____

Start Date: _____
 Ship Meds: Home Doctor's Office
 Teaching by: Doctor's Office
 Other: _____

INSURANCE INFORMATION

Insurance: Medicare Medicaid Commercial: _____
 ID _____ BIN _____ PCN _____ GROUP _____

Diagnosis: Rheumatoid Arthritis Ankylosing Spondylitis Osteoporosis Psoriatic Arthritis Lupus Gout Spondyloarthropathy
 Uveitis Date of Diagnosis: _____
Prior Treatment: Humira Enbrel Stelara Others: _____ **TB Test** Positive Negative

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162mg <input type="checkbox"/> _____mg	INJECTION	<input type="checkbox"/> Less than 100kg weight: Inject 162mg subq every other week, followed by an increase to every week based on clinical response. <input type="checkbox"/> Above 100kg weight: Inject 162mg subq every week. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> 200mg/1ml Prefilled Syringe <input type="checkbox"/> 200mg Vial		<input type="checkbox"/> Induction Dose: Inject 400mg subcutaneously on day 1, at week 2, and at week 4. <input type="checkbox"/> Maint. Dose: Inject 200mg subcutaneously every other week. <input type="checkbox"/> Maint. Dose: Inject 400mg subcutaneously every 4 weeks.		
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 300mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS <input type="checkbox"/> 150mg <input type="checkbox"/> Pen <input type="checkbox"/> PFS		<input type="checkbox"/> Initial Dose: Inject 300mg subq at weeks 0,1,2,3, and 4 weeks. Each 300mg dose is given as 2 subq inj of 150mg. <input type="checkbox"/> Maint Dose: Inject 300mg subq once 4 weeks. Each 300mg dose is given as 2 subq inj of 150mg.		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with Auto Touch <input type="checkbox"/> Prefilled Syringe <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> Vials 25mg		<input type="checkbox"/> Inject 50mg SQ every week <input type="checkbox"/> Inject 25mg SQ TWICE a week (72-96 hours apart). <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Humira	<input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Pre-Filled Syringe <input type="checkbox"/> 80mg Pen		<input type="checkbox"/> Uveitis Initial Dose: Inject 80mg Subq on day 1, 40mg on day 8 and 40mg day 22 then maintenance. <input type="checkbox"/> Maintenance Dose: Inject 40mg Subq every other week. <input type="checkbox"/> Maintenance Dose: Inject 40mg Subq weekly.		
<input type="checkbox"/> Humira CF (Citrate-free)	<input type="checkbox"/> Uveitis Starter Kit <input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg Pre-Filled Syringe <input type="checkbox"/> 80mg Pen		<input type="checkbox"/> Uveitis Initial Dose: Inject 80mg Subq on day 1, 40mg on day 8 and 40mg day 22 then maintenance. <input type="checkbox"/> Maintenance Dose: Inject 40mg Subq every other week. <input type="checkbox"/> Maintenance Dose: Inject 40mg Subq weekly.		
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 200mg <input type="checkbox"/> 150mg		<input type="checkbox"/> Inject 200mg subcutaneously once every two weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Otrexup	<input type="checkbox"/> _____mg/ml		<input type="checkbox"/> Inject _____mg Subcutaneously Once a week.		
<input type="checkbox"/> Rasuvo	<input type="checkbox"/> _____mg/ml		<input type="checkbox"/> Inject _____mg Subcutaneously Once a week.		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 45mg Prefilled Syringe <input type="checkbox"/> 90mg Prefilled Syringe		<input type="checkbox"/> Inject 45mg SQ at weeks 0, 4 & then every 12 weeks. <input type="checkbox"/> Inject 90mg SQ at weeks 0, 4 & then every 12 weeks.		
<input type="checkbox"/> Simponi	<input type="checkbox"/> 50mg/0.5ml Prefilled SmartJect Autoinjector <input type="checkbox"/> 50mg/0.5ml Prefilled Syringe		<input type="checkbox"/> Inject 50mg (0.5ml) subcutaneously once a month. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Forteo	<input type="checkbox"/> 600ug/2.4 ml Delivery Device		<input type="checkbox"/> Inject 20ug (0.08 ml) Subcutaneously Once daily.		
<input type="checkbox"/> Prolia	<input type="checkbox"/> 60mg/ml		<input type="checkbox"/> Inject 60mg/ml Subcutaneously Once every 6 months. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Tymlos	<input type="checkbox"/> 3120mcg/1.56ml		<input type="checkbox"/> Inject 80mcg Subq once daily.		
<input type="checkbox"/> Taltz	<input type="checkbox"/> 80mg/ml Autoinjector <input type="checkbox"/> 80mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 160mg Subcutaneously (two 80mg injections) at week 0, followed by 80mg every 4 weeks. <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablet	ORAL	<input type="checkbox"/> Titrate: Take 1 tablet on day 1 then twice daily as directed OR date provided _____ <input type="checkbox"/> Maintenance: Take 1 tablet by mouth twice daily. <input type="checkbox"/> Bridge RX: Take 1 tablet by mouth twice daily; disp. by OSP.		
<input type="checkbox"/> Olumiant	<input type="checkbox"/> 2mg		<input type="checkbox"/> Take 2mg PO Once daily.		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> 5mg		<input type="checkbox"/> Take 5mg PO Twice a day.		
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> 11mg		<input type="checkbox"/> Take 11mg PO Once daily.		

Physician Signature: _____ DAW (Dispense as Written) Date: _____
 Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____
 Physician Address: _____ NPI: _____ DEA: _____

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RHEUMATOLOGY ENROLLMENT FORM - "INFUSION"

PATIENT INFORMATION

Last Name _____ First Name _____
 Social Security # _____ Date of Birth _____
 Address: _____
 Sex M F Wgt: _____ Ht: _____ Phone: _____
 Allergies: _____ Cell: _____

TREATMENT ARRANGEMENTS

Start Date: _____
 Ship Meds: Home Doctor's Office
 Teaching by: Doctor's Office
 Other: _____

Diagnosis: Rheumatoid Arthritis Ankylosing Spondylitis Osteoporosis Psoriatic Arthritis Lupus Gout Spondyloarthropathy
 Date of Diagnosis: _____

INSURANCE INFORMATION

Insurance: Medicare Medicaid Commercial: _____
 ID _____ BIN _____ PCN _____ GROUP _____

Premeds: Tylenol 500mg 2 PO Loratidine 10mg PO Zyrtec 10mg PO Benadryl _____ mg IV/PO (circle one)
 SoluCortef _____ mg IV Ondansetron _____ mg IV Promethazine _____ mg IV Other _____

Standing Order: Anaphylaxis Protocol **Skilled Nurse to start PIV, infuse per protocol, DC PIV each visit**

Lab Draw As Follows: _____

Quantiferon Gold Lab Draw Q _____ Patient to FU w/MD Q _____

Prior Treatment: Humira Enbrel Stelara Others: _____ **TB Test** Positive Negative

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Actemra	<input type="checkbox"/> 80mg/4ml <input type="checkbox"/> 200mg/10ml <input type="checkbox"/> 400mg/20ml <input type="checkbox"/> _____ mg/kg	IV	<input type="checkbox"/> Induction Dose: 4 mg/kg every 4 weeks. <input type="checkbox"/> Maint. Dose: (based on clinical response): 8 mg/kg every 4 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 10mg/kg		<input type="checkbox"/> Induction Dose: Administer 10 mg/kg on week 0, week 2 week 4. <input type="checkbox"/> Maint. Dose: 10 mg/kg once every 4 weeks after Induction dose. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Boniva	<input type="checkbox"/> 3mg/3ml Injection		<input type="checkbox"/> Inject 3mg/ml Once every 3 months. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Krystexxa	<input type="checkbox"/> 8mg/ml		<input type="checkbox"/> Inject 8mg/ml Intravenous once every 2 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Orencia	<input type="checkbox"/> 250mg Vial <input type="checkbox"/> _____ mg/kg		<input type="checkbox"/> Infuse _____ mg in 100ml of 0.9% NaCl at weeks 0, 2, and 4, then every 4 weeks thereafter. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Remicade	<input type="checkbox"/> 100mg Vial <input type="checkbox"/> 300mg/kg		<input type="checkbox"/> Induction Dose: IV in 250ml of 0.9% NaCl at weeks 0, 2, and 6 weeks. <input type="checkbox"/> Maint. Dose: IV in 250ml of 0.9% NaCl every 8 weeks. <input type="checkbox"/> Maint. Dose: IV in 250ml of 0.9% NaCl every 6 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Rituxan	<input type="checkbox"/> 100mg/10ml vial <input type="checkbox"/> 500mg/50ml vial		<input type="checkbox"/> Infuse two doses of 100mg in 1 liter of 0.9% NaCl separated by 2 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Reclast	<input type="checkbox"/> 5mg/100ml		<input type="checkbox"/> 5mg/100ml Once every year. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Simponi Aria	<input type="checkbox"/> _____ mg/kg		<input type="checkbox"/> Inject 2 mg/kg intravenous (IV) infusion over 30 minutes at Weeks 0 and 4, then every 8 weeks thereafter <input type="checkbox"/> Other: _____		

Physician Signature: _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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